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Uncovering hidden emotional work: professional practice in paediatric post-mortem

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Abstract

The concepts of emotional labour and emotion management have been extensively explored across a range of health and social care occupations. Less is known about emotionality in ‘hidden’ and ‘taboo’ realms of health work. Drawing on data from an ethnographic study on fetal and neonatal post-mortem, we explore the ways in which professionals across occupation and status positions both articulate and manage their emotions. Post-mortem involves a range of practices which take place around the edges of life and death, medicine and hospital space. Although often concealed from members of the public (and from some professionals), such practices tend to be highly valued by professionals and parents. Our analysis moves beyond the current sociological focus on occupation, illuminating instead how emotional work is performed across multi-disciplinary teams in this secret context. In doing so we seek to contribute to the conceptual and empirical development of the sociology of emotion work.

Keywords: Emotional Work, Emotion Management, Hidden Work, Paediatric Post-Mortem

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Introduction

Sociological research often portrays emotion work as hard and productive labour, requiring health care professionals to employ a range of strategies in order to manage their emotions (Bolton and Boyd 2003). While studies have covered a range of areas of health work from paramedic practice to palliative care (Boyle 2005, James 1989), they have tended to focus their analysis on particular occupational groups. Certain health occupations such as nursing have been particularly well represented in this literature. This is largely because these groups have tended to perform the bulk of emotional work, work which is then often gendered and marginalised (McCreight 2005). Little is known, however, about how professionals involved in hidden' and 'taboo' work such as post-mortem articulate and manage their emotions in sensitive settings.

While ethnographic studies on post-mortem have grown in number in recent years, much of this research has focused on dissection, forensic pathology and traumatic death (Brysiewicz 2007, Timmermans 2006). Certain areas of pathology (including paediatrics) have been neglected, along with the views of other professional groups whose work might inform post-mortem practice (such as midwives). Drawing on data from an ethnographic study on fetal and neonatal post-mortem, this paper sheds light on this hidden work, illuminating aspects of emotional work that professionals often find rewarding in this sensitive setting. The article seeks to uncover a range of practices that are often concealed from public view. By including professionals across a diverse range of occupational groups, and by exposing hidden emotional work this paper seeks to offer an original contribution to existing studies on the sociology of emotions and ethnographic research on post-mortem.

In the following section we begin by outlining background literature along with the project's conceptual focus and method. The main part of the article is concerned with a discussion of the findings of the study presented in three sections: managing emotions across life and death, hidden care and emotion management in paediatric post-mortem, and the changing nature of emotional work. We show how professionals articulate and manage their emotions in similar ways across a diverse range of occupational groups and status positions. In doing so we seek to move beyond the predominant focus in existing literature on emotional work as marginalised labour associated with particular occupations. Our paper concludes by emphasising the increasing value placed on the role of emotions in post-mortem work. We consider how this may be indicative of a wider affective turn in labour and production, with emotions becoming more deeply embedded in a broader range of work practices (Hardt 2007).

The sociology of emotional work in healthcare

While the concept of emotional labour was developed initially within research on commercial services (Hochschild 1983), sociologists have increasingly focused on exploring emotional work in a range of health and social care settings- such as in nursing, healthcare assistants, paramedic work and professions associated with bereavement (Bolton, 2000; Boyle 2005; Hockey, 1993, Kessler et al 2015, Lewis 2005). Studies have drawn attention to the kinds of feelings articulated in different healthcare settings- such as sadness over a poor patient prognosis or happiness at the birth of a baby- and to the various strategies that health care workers employ in order to deal with their emotions.

Bolton and Boyd (2003) developed the concept of emotion management, acknowledging the role of individual agency within this form of work. They identify four types of emotional

management skills that professionals draw on in different contexts. These range from presentational (emotion management according to general social 'rules'), pecuniary (emotion management for commercial gain), prescriptive (emotional management according to organisational/professional rules of conduct), and philanthropic (emotion management given as a gift). Bolton (2005) also emphasises the differing underlying motivations for these strategies. While prescriptive and pecuniary emotion management strategies draw on organisational and professional norms of behaviour, philanthropic and presentational forms draw on social norms. Professionals however may exert differing degrees of agency in how and when they utilise these skills, and sometimes these strategies conflict. At other times particular forms of emotion management dominate. For example, philanthropic and professional forms tend to feature strongly in emotional work related to death and dying (Bailey 2010, Lewis 2005). Drawing on Goffman's (1959) dramaturgical metaphor research has also highlighted the different ways in which professionals both show and manage emotions 'frontstage' with patients and publics and 'backstage' at home (Bolton 2001, Boyle 2005). Healthcare professionals are often viewed as emotional jugglers who are able to 'match face with situation' (Bolton 2001: 86).

The emotional strain that doctors experience as part of their job is recognised by existing research (Larson 2005, Nettleton et al 2008). Studies tend to concentrate their analysis, however, on the ways in which certain professional groups- such as nurses- perform the bulk of emotional work, work which is then often viewed as marginalised, feminised and devalued (McCreight 2005). In her study of hospice nurses, James (1989) shows how emotional work is one component of a broader range of care practices and as such is subject to a professional division of labour. Lewis (2005) also argues that while both doctors and nurses do emotion work, there tends to be a clash between the 'masculinized' prescriptive-professional form of

emotion management performed by doctors and the ‘feminised’ philanthropic-gift form often performed by nurses. While articulating and managing emotions is undoubtedly hard work, it can also be a productive and positive experience for professionals (Wouters 1989). For example, in their study on gynaecology nurses Purcell et al (2017) show how emotional labour offers a means of facilitating the completion of the practical body work tasks associated with abortion. As Lewis (2005) notes, however, while emotional work is often personally rewarding, it continues to be undervalued and undeserving of financial reward—particularly, she argues when in philanthropic form.

While sociologists have emphasised the need to understand how emotional work varies across contexts (Wharton and Erickson 1993), existing literature continues to focus on specific occupations. The increasing use of technologies, protocols and clinical pathways is, however, having a significant effect on occupational boundaries within healthcare (Hunter and Segrott 2014), potentially reconfiguring occupational identity and along with it the possibility of who gives care and how. It also indicates a potential move towards inter-professional collaboration and multi-disciplinary teamwork (Reed et al 2016), thus requiring sociological analyses of emotional work that go beyond occupation.

This paper contributes to the conceptual development of the sociology of emotional work by demonstrating the value of moving beyond the current analytical pre-occupation with occupation. We explore emotional work as articulated by a range of professionals whose work practices inform post-mortem. Post-mortem is a complicated process that may vary according to when and where a baby has died and whether it is a hospital consented post-mortem or one which has been ordered by the coronerⁱ. Beginning our analysis with a focus on what happens once a baby has died, we aim to shed light on how emotional work is

performed in various ways across occupational groups and hierarchies in difficult, often highly charged, emotional settings. We use the umbrella term emotional work in order to consider a range of issues: the feelings professionals articulate in this sensitive work context, the connection between emotions and care work and the emotional management strategies professionals adopt in order to cope with their own and others emotions. Building on existing literature we seek to highlight the importance of philanthropic and professional forms of emotion management in work practices associated with death and dying (Bailey 2010, Lewis 2005). We move away, however, from focusing specifically on emotional work as marginalised labour associated with particular occupations. We focus instead on exploring the ways in which emotion work is articulated across multi-disciplinary teams, highlighting the personal satisfaction professionals often gain knowing that they have provided parents with crucial forms of support during this deeply traumatic time.

Paediatric post-mortem as hidden work

Sociologists have, for some time, focused on the ways in which death is hidden within contemporary society. According to Baudrillard (1993), for example, one of the key differences between ‘savage’ societies and modern capitalist society is that the dead have become further removed from the living (Benzer and Reed 2019). According to Mellor and Shilling (1993) death has shifted from the public realm to the private world of individualised experience. The preparing and disposing of bodies has become less familiar in everyday terms and increasingly institutionalised, professionalised and privatised (Mellor and Shilling 1993). It is therefore unsurprising perhaps that so called ‘death work’ is often ‘hidden’ from public view. Corpse dissection and post-mortem, for example, has remained closed to public eyes over the last century. Mortuaries are locked,

regulated places largely hidden from members of the public and from some hospital staff (Stephens 2011).

The fact that post-mortem work goes on ‘behind closed doors’, coupled with its particular association with dead bodies has meant that sociologists have often explored it through the lens of dirty or tainted work (Ashforth and Kreiner 1999). More recently however research has attempted to present a more enlightened vision of post-mortem. Gassaway (2007) for example, argues that pathologists provide essential answers for families about why a loved one has died, thus preventing the label of taint from attaching itself to them. Woothorpe and Komaromy (2013) also show that through education and the promotion of their activities mortuary technicians (APTs) are developing a ‘community of practice’ that transcends an outdated perception of mortuary work as ‘dirty work’. This positive portrayal of post-mortem in recent research reflects the increasing visibility of such work in contemporary popular culture. For example, post-mortem is now widely represented in television dramasⁱⁱ as highly-skilled, professional work.

While qualitative research on post-mortem has increased, existing studies tend to focus on the profession of pathology and on certain sub-specialisms within it, for example anatomical (Horsely 2012), or forensic pathology (Gassaway 2007). Particular attention is often lavished on forensic pathology, and on the scientific rather than emotional aspects of post-mortem (Brysiewicz 2007, Timmermans 2006). Research that does include a focus on emotional labour tends to concentrate on the ways in which professionals working with dead bodies try to avoid situations that humanise the body in order to create emotional distance (McCarroll et al 1993). Certain sub-specialties within pathology are overlooked too, for example Paediatric post-mortem. This is an emotive and taboo area of post-mortem- particularly in the aftermath

of the organ retention scandal of 1999 when it was discovered that bodily organs and tissues from babies and children were being used by some UK hospitals for purposes other than autopsy (Sheach Leith 2007). While the sociological significance of this sub-specialty has been highlighted (Prior 1987), it has yet to form the core focus of in-depth empirical research. This article offers a sociological analysis of emotion work on the taboo and neglected subject of fetal and neonatal post-mortem. By focusing on paediatric pathology, and uncovering hidden emotional work, this article offers an empirical contribution to the sociology of emotions and also provides a fresh angle to existing ethnographic studies on post-mortem.

The Study

The material used in this paper to explore the role of emotional work in post-mortem practice was drawn from a larger study on the emerging use of Magnetic Resonance Imaging (MRI) in fetal and neonatal post-mortem. The study was funded by the Economic and Social Research Council and ethical approval was received from the UK National Research Ethics Service. It was based primarily in a mortuary connected to a Histopathologyⁱⁱⁱ department at a teaching hospital in the north of England. We negotiated access to the mortuary and to staff located there via NHS collaborators and a clinical co-applicant. The research design was informed by an advisory team consisting of various professionals, representatives from bereavement charities (including bereaved parents) and one manufacturer of MRI systems.

We sought to understand – from a professional perspective- what happens when a baby dies. In order to do this we included 27 professionals from a range of occupational groups into our study- from midwives through to pathologists and police officers. The study included 10 male and 17 female respondents of a range of ages. However, while emotional work was conducted by men and women, we do not feel that we have sufficient data to make a gender

based comparison in this paper. We recruited participants in junior and senior posts (from trainee doctors to senior consultants). The sample included respondents in low-paid roles (assistant bereavement support officers) as well as those in senior status positions (clinical heads of department). Professionals had worked in their roles from between 6 months and 35 years. Due to limits of word-length, however, it is not possible to include accounts from all professionals participating in the study within the context of this paper.

We sought to adopt a methodological approach responsive to the needs of respondents and to particular fieldwork contexts. Our approach was informed by go-along ethnography, a hybrid method involving interviewing and participant observation with research participants in their own environments (Reed and Ellis 2018). We spent time with respondents in a range of physical spaces – across the hospital and beyond. We conducted interviews with all 27 respondents at some point during the study, combining these with ethnographic observations and respondent-led tours as appropriate. This flexible approach enabled us to build an understanding of the complex and sensitive nature of post-mortem. We also conducted interviews with bereaved parents and family members. However, parent experience is not the focus of this paper and is explored elsewhere.

Data collection and analysis

The fieldwork was conducted over a period of 18 months by Kate and Julie who are both sociologists. We sought ethical approval prior to conducting the research, securing further approvals as the project progressed in order to extend recruitment and allow for in-depth ethnographic work in the mortuary. We began visiting the mortuary both collectively and individually - conducting semi-structured interviews, observations and tours. We began by asking staff to tell us about their work practices, sometimes as they were actively engaged in

these practices. We observed minimally invasive post-mortems (MIAs) in the mortuary and were attentive to the role and movement of objects in post-mortem practice. We often followed respondents as they went about their day-to-day work practices in different locations. By adopting this flexible and mobile approach we were able to appreciate the ways in which different aspects of post-mortem work occurs in different locations.

Arber (2006) suggests that the credibility and reliability of data can be improved by identifying the status and position of the researcher. We reflected on our position as social scientists throughout data collection and analysis evaluating the potential effects this might have on the research process. Professionals appeared to welcome the opportunity to show us around their workplaces and talk to us about their professional roles. As part of ethical approval we were required to gain consent from the lead pathologist for post-mortem observations. She was supportive of the research and we were always granted access in these cases. Patient information during mortuary observations remained confidential and members of the research team were never present when families were visiting the mortuary. We were concerned about the effects of clinical observations on our own emotional well-being.

However professionals were sensitive about how they introduced us to clinical work, making sure that we were fully informed about what we might witness during an examination.

Professionals appeared keen to demystify post-mortem work. In particular they wanted to expose us to the hidden care practices that take place in the mortuary, hospital and beyond.

We digitally recorded interviews and took brief notes during the observations and interviews, turning these into fuller accounts afterwards (Walford, 2009). Fieldnotes are partial records, but as Atkinson (1992) shows they do allow the researcher to recapture significant actions and build ethnographic context into the research. Once we started generating a body of

fieldnotes and interview transcripts we began to analyse the data drawing on a thematic approach. We sought to categorise, summarise and reconstitute data in order to identify emerging themes and concepts (Braun and Clarke, 2006). This was an iterative process which took place throughout data collection. We did not set out explicitly to explore emotional work. However, as we analysed the data it became apparent that emotion work and care practices were central to the post-mortem process. As we coded data we reflected back on its relationship to the different types of emotion work and management strategies as identified in the wider literature (Bolton and Boyd 2003). We now seek to illustrate - using fieldnotes and interview excerpts – how professionals show their feelings and manage emotions, focusing initially on the start of the post-mortem journey.

Managing emotions across life and death

Professionals working at the start of the post-mortem journey (such as midwives and obstetricians) were often dealing acutely with issues of life and death, requiring them to be ‘emotional jugglers’ (Bolton 2001). This was similar to Lewis’s (2005) study where neonatal nurses were often required to be caring and professional, oscillating between philanthropic and professional forms of emotion management depending on an individual baby’s prognosis. In the hospital where this study took place midwives currently do not take consent for post-mortem. They are, however, often the first people to mention post-mortem to parents after the death of their baby. The midwives have to work through a bereavement checklist asking parents whether they might want to consider a post-mortem. We interviewed Wendy- a senior midwife, who informed us that managing the loss of a baby on labour ward is not an infrequent event (occurring around 1-2 times a month), and requires midwives to juggle different emotions as the quote below suggests:

The hardest thing that some of us have experienced is you can be looking after two women and one of them has a live baby and she's in labour, or she's delivered. So she's got this baby and it's crying and you're helping her breastfeed. And then next door you're also looking after a lady who's lost her baby. So you've got a sad, happy face going on. And it's almost like... It would be funny if it wasn't so awful, is that you've got to think before you go in a room who is this? What kind of outlook do I need here? And who is this? And this is a happy moment and I don't want to spoil it for them (Wendy, Senior Midwife).

Research has emphasised the ways in which professionals often manage sad situations by putting on a brave face in public and then releasing emotions in private (Boyle 2007). Wendy also talked about managing her sadness by having a cry in private in the 'dirty sluice' at work^{iv}. Many respondents discussed the importance of creating and maintaining a baby's personhood across the boundaries of life and death. In this instance professionals tended to articulate a philanthropic form of emotion management. We interviewed a consultant obstetrician-Gina- who looked after women throughout pregnancy, during delivery and post-birth and who also takes consent for post-mortem. Gina is very involved in counselling women and likes to have sustained relationships sometimes supporting women through multiple pregnancies. Gina was honest about the emotional aspects of her work and talked movingly about the importance of going to see babies after they have died. This is useful to her as a clinician. She also felt that it helps women who are frightened to see the baby:

.....I remember one lady in particular who actually had a baby with anencephaly where the back of the skull hasn't formed at all and she was quite an intelligent lady and didn't want to see her baby at all and I said are you sure you don't want

to see your.....and she said I don't know, I don't know what I think, I said well look why don't we just gradually take it step by step and just tell me if you don't want it I literally just undressed baby from feet to...and she held her baby's feet and.... and the hands and so on but she then didn't feel she could go to the head..... because of the abnormality, do you see what I mean, but we got to sort of here... which was all very normal, do you see? I remember her saying to me afterwards I was so pleased you spent that time and did that with me (Gina, Consultant Obstetrician)

Once a baby has died in hospital (e.g. on labour ward or the Neonatal Surgical Unit, NSU) the next step often involves moving them to the mortuary for post-mortem. During this process different professionals from across the hospital would visit the mortuary to pay their respects to the family- thus emphasising the importance of emotional teamwork across professional groups. Tracey, for example, a paediatric surgical nurse (a sister) who worked on the neonatal surgical unit talked about building up a relationship with '*Primrose Villa*' (the mortuary) over time. She told us that it is rare that staff experience deaths working on NSU – although unusually they have dealt with two deaths already this year. Tracey explained that she uses a combination of personal and professional strategies to manage the death of a baby. She doesn't have a 'formal' role in the post-mortem process but does support families contemplating post-mortem by reassuring them that their baby will be well cared for by the mortuary team. Tracey emphasised the importance of visiting the mortuary with the senior paediatric surgeon to pay her respects to families after a baby on their unit had died.

They (the family) asked me to, I'd been down (to the mortuary) to see them, and I'd gone down with the paediatric surgeon, 'cause I was going down to see them,

and he wanted to go down, so we went down together to see the baby and the family, and then, a couple of days later, the mortician, Carmen, rang up to say that mum wanted to speak to me, mum wanted me to go down again, and I went down, and she was telling me all about the funeral and things like that. So, it's important for the family..... but also it is part of your job, just because they've died, they're still your patient, it's part of looking after the patient and the family (Tracey, Surgical Nurse).

Our data show that professionals working at the start of the post-mortem journey- across life and death- often adopt different 'faces' to match face to the situation (Bolton 2001, Boyle 2007), drawing in particular on philanthropic and professional forms of emotion management as appropriate (Lewis 2005). While the professionals had different clinical roles, they were all engaged in similar types of emotional work primarily aimed at assisting parents in coping with the death of a baby. Hospital staff tended to work across multi-disciplinary teams to support parents and families. This reinforces the value of moving our analysis beyond occupation to explore emotional work across professions, and status positions. We will build on this argument in the following section as we explore some of the hidden emotion work that takes place in the mortuary during the post-mortem examination.

Paediatric post-mortem: hidden care work and emotion management

In her study of hospice nurses, James (1989) showed how emotional work is one of the key elements of care work in healthcare. In this section we seek to explore the connection between caring and emotion work, focusing our analysis on the physical part of the post-mortem. This examination takes place in the mortuary and is performed by a trained pathologist who is supported by a mortuary technician (APT). Although post-mortem work

is now widely represented in research and in popular culture as highly-skilled, professional work, the emphasis tends to be on the scientific or forensic aspects of post-mortem and less on the emotional or caring aspects. We visited *Primrose Villa* frequently during the course of our research to conduct observations. During one of these occasions we observed two MIA post-mortems- one performed on a 21 week old fetus, the other on a baby who had died at 4 months old. As we observed these post-mortems we were struck by the care and attention that the pathologists and APT gave to both babies as they were performing the examination. In the fieldnotes below we describe some of these care practices

I notice as Brent (pathologist) talks and tells us about this little girl who is 4 months old and who has been ill for much of her short life (latterly receiving palliative care) that he gently taps the child in a reassuring way (Mortuary notes).

The deaths of infants and children tend to be regarded as worthy of maximum investigative resources in post-mortem (Prior 1987). However, our respondents often felt that paediatric pathology operated around the fringes of the sub-speciality of pathology. Ruth, a trainee pathologist discussed the ways in which members of the public were often shocked or fascinated when she told them she was a paediatric pathologist. She felt paediatric pathology was different from adult pathology involving more direct collaborative team-working. Ruth felt unsure initially about how she would manage conducting post-mortems on children and babies, making reference to the upsetting aspects of her work. However, she felt she was doing something good for families overall by trying to provide them with information. She drew attention particularly to the ways in which babies were cared for and their personhood respected in the mortuary. Pathologists and APTs would articulate their emotions to the baby and to one another during the clinical examination. Because post-mortem is hidden- taking

place behind locked doors- parents, publics and staff working in other parts of the hospital don't always know that this kind of care work exists in the mortuary:

I find that when we have a baby come in, and we'll be like, oh that's a nice baby. And I don't think I talk about it as if it's dead, one of the mortuary techs brought a new one in, and we were all just like, oh isn't she lovely? Like, we don't think of it as, oh but she's not lovely anymore because she's died. You could tell it was a really beautiful child and stuff. So, I suppose, in some ways, we talk about them like that, so it is quite, yeah, I suppose that's the main difference (from adult pathology), I think people wouldn't expect really, to imagine that we see them (babies) as something different (Ruth, Trainee Pathologist).

Paediatric pathologists and APTs found the emotional and caring aspects of their role rewarding. This work was often conducted out of respect for both the baby and parents. Knowing that they had looked after a baby well during the examination, gave professionals a significant degree of job satisfaction. Emotional work in this context however was also a way that professionals managed their own feelings. It could act as a coping mechanism for the difficult and upsetting parts of their job, again demonstrating the prevalence in this arena of a philanthropic form of emotion management. We spent time with Carmen in the mortuary, conducting mobile observations and a sit down interview. She had worked as a mortuary technician for many years and talked very movingly about how she cared for and prepared the babies both before and after the clinical examination- dressing, bathing and making them look nice for family viewing. She emphasised the ways in which this helped her to deal with the emotionally challenging side of the job:

Well I personally, and it may sound like I'm a bit daft I think (laughs), but I talk to them (babies), so I always treat them like they're still alive, so that's how I manage to get through it, so I'll pick them up and say, oh, come on then let's get you ready, let's do this, let's do that, so I talk to them all the way through, and yes I know they're dead, and yes I realise that they might not even look that nice but to me...I mean I lost a baby a long time ago and I just know how I felt and I know that everyone else's experience is not going to be the same as mine but I know how I would have wanted someone to look after mine and so I always treat them the way that I would expect anyone to treat me or my child, because I think that those memories just last forever and one smile or one kind word I think just goes a thousand miles, you know, you're in that person's life for just a small amount of time and you can make so much difference between it being an absolutely terrible experience, which it is terrible but you don't want to make it any worse (Carmen, APT).

Emotional work forms part of a broader range of care practices as highlighted by existing literature (James 1989). During the clinical examination however this form of emotional work often remains hidden from members of the public – and sometimes from parents and other professionals too. Because of the particularly taboo nature of paediatric post-mortem practice, emotional work conducted during the examination is visible mostly to other professionals involved. Both APTs (allied health professionals) and pathologists (doctors) perform this philanthropic and caring form of emotion work in similar ways. Uncovering this hidden work, therefore, enables us to challenge perceptions of post-mortem work as solely clinical, scientific work, and also takes us beyond specific associations of emotional work

with specific health professionals. We move on now in the final data section to consider the changing nature and role of emotional work.

The changing nature of emotion work

The personal value professionals ascribe to emotional work is often emphasised in existing research, particularly in light of the increasing bureaucratisation of work (Bolton 2000, Twigg et al 2011). Despite this positive experience, however, sociologists often argue that emotion management-particularly philanthropic forms- still tend to be viewed as natural, and female, and as undeserving of financial reward (Lewis 2005). In this section we explore the ways in which emotion work is highly valued by professionals in our study. Despite occupying a place on the peripheries of clinical or technical work, it is also becoming a more central and accepted form of post-mortem practice. For example, Nell, a medical photographer emphasised the importance of being technically accurate in her job. She would often take photographs of deceased babies for families before post-mortem, either in the mortuary or bereavement suite. It was, however, often the hidden side of her job that she enjoyed most- the emotional patient-facing side. Providing parents with a good photograph demonstrates a philanthropic form of emotion management, emotional work as a gift to the parents (Lewis 2005):

As photographers you are creative and we have to be technically right with what we're doing, but there's no side for the creativity. And the caring side, if you work with patients you generally want to be with the patient. That's the side I really enjoy. And I know Jo's the same and we've both got two children each and I think we see that side, that we could give them more to add to it in this horribly traumatic time. If we could just give them something nice, pretty, you

know, attractive, just a nice memory, a better way of looking at it than mobile phone pictures I suppose, if we could add something that we're good at and our strengths into that that's what we would want to do. But it's hard (Nell, Medical Photographer).

We spent a significant amount of time with the most senior paediatric pathologist in the hospital- Ava- conducting both interviews and observations. Ava told us that the reason she specialised in pathology after completing her medical training was because she could not bear to deal with the pain of the living. The clinical examination formed the centre point of the post-mortem journey. While the main aim of the examination is to establish cause of death, Ava also emphasised the importance of offering families emotional support, in her words 'giving them (parents) the words that they need, the reassurance that they need to support their grief'. Ava did this in various different ways, for example, by commenting and remembering a baby's beautiful face or hair, and by informing families that their baby was not in pain when they died. She felt that parents found this information comforting, often helping to assuage them of the guilt they felt when their baby had died. The juxtaposition of clinical and emotional aspects of work was something articulated by many professionals such as the APT, Carmen, as illustrated by the notes below:

As we take our tour of the mortuary, Carmen describes her role having two key areas of expertise – knowing about anatomy but also knowing about how to be with parents and families (Mortuary notes).

When it came to performing the actual clinical examination, Ava discussed the need to keep her emotions in check. Emotion management in this context did not necessarily involve

creating emotional distance from the dead person as other studies have often shown (McCarroll et al 1993). Ava managed her emotions by drawing on a combination of philanthropic and professional forms of emotion management. In order to maintain her clinical focus she did not meet with parents until after the examination. Once she had completed her examination and could give parents information about cause of death, then she would become emotional, sometimes crying with them:

Of course, sometimes you cry, with them, and you hold their hands, and you become emotional. But you leave the room and you are detached. Of course you remember cases. I remember all my babies, some ones more than others, but one trick for me is not to meet the family before (Ava, Pathologist).

While often hidden, our data also suggest that emotional work is becoming a more integrated part of the post-mortem process. This can be illustrated by changes to the way Sudden Infant Death Syndrome (SIDS) is managed. During his medical career Dave, a neonatologist, had played a pivotal role in supporting families in cases of SIDS where a baby has died suddenly of unknown causes. These are complex cases often requiring a multi-agency response (including the police) and a coronial post-mortem. Dave emphasised the importance of going to see families soon after the baby's death and before the post-mortem examination, ideally within 12 to 24 hours. There are three to five SIDS cases per year in this particular locality. Dave emphasised the ways in which clinicians and charities had worked together to decriminalise SIDS over time, emotional support becoming an accepted aspect of multi-agency professional practice. He was very proud of this aspect of his work and felt that helping parents in this way was beneficial to him as a clinician:

...what I get out of it is trying to help the parents. Of course these are sad situations, of course you might feel emotional about them but actually what you're trying to do is help the parents through that difficult time you have to bear in mind that going back to the '90s, very often the child would be brought in dead to casualty. They wouldn't necessarily see much of a paediatrician. There'd be no follow-up from a paediatrician. There would be a phone call from the coroner's office saying the child needs a post-mortem and there may not be feedback from that post-mortem for the family. The family are left in complete limbo and the police had put a cordon around the house. So now it's a much more organised and supportive response to these tragedies (Dave, Neonatologist).

While emotional work often occupied a secondary role to technical or clinical aspects of work, all professionals in our study clearly valued it. This was particularly the case with philanthropic forms of emotion management. Knowing that they had done their best for parents by caring for the baby and providing emotional support at different points in the post-mortem journey gave professionals a strong sense of pride and job satisfaction. It also helped them to manage their own emotions. As Dave's quote shows, emotion work is beginning to take a more central place in the post-mortem process. As we will explore in the conclusion, this could be indicative of what sociologists such as Hardt (2007) call an affective turn in production, whereby emotional labour is becoming increasingly embedded in various forms of work.

Conclusion

We have sought to contribute to the existing conceptual and empirical development of the sociology of emotional work in this paper in two respects; firstly through shedding light on emotional work that is articulated and managed in the under-researched and hidden arena of paediatric post-mortem and secondly by moving beyond an analytical focus on occupation to explore the ways in which emotional work is performed across multi-disciplinary teams. We recognise that there is a specific emotional sensitivity around work involving the death of a baby. However, by trying to understand the various ways in which emotions are articulated and managed across the post-mortem journey this article has sought to offer an original contribution to existing sociological work in the field.

Our data shows how professionals often juggle emotions in this sensitive arena- from acute sadness to more life affirming emotions. Respondents tended to exert philanthropic forms of emotion management most frequently when talking to parents about post-mortem. They often switched to professional forms of emotion management when they needed to be more detached in order to perform an actual physical examination (Lewis 2005). Our data also shows how emotional work tended to operate as a form of care work (James 1989).

Emotional work taking place at the start of the post-mortem journey, however, was often aimed at, and visible to parents. In contrast, emotional work conducted in the mortuary during post-mortem (e.g. singing and talking to babies) was often hidden and inaccessible to parents, other professionals and members of the public. This indicates some variation in how emotions were articulated and managed across the post-mortem journey. More importantly perhaps, it problematizes the boundaries between ‘front’ and ‘backstage’ forms of emotion work and management. In order to provide a better account of emotional work in settings where the majority of work practices take place behind closed doors, therefore, sociologists

should seek to move beyond their existing application of Goffman's (1959) dramaturgical metaphor in this context.

Although research highlights the personal value of emotional work (Bolton 2000, Twigg et al 2011), it tends to focus on the ways in which emotional work- particularly philanthropic forms- continue to be marginalised and feminised (Lewis 2005). Such research is, however, limited by its focus on particular occupations (Bolton 2001, Lewis 2005). By moving beyond occupation, we have sought to show how various professionals engage in and value philanthropic forms of emotion work regardless of profession, status position or even gender. Rather than invalidating the concepts of emotional work and management, however, we suggest this emphasises their applicability beyond specific units of analysis such as occupation. Given the increasing shift towards multi-disciplinary team working, we suggest sociologists extend their existing focus, exploring emotional work and management along different clinical or other workplace pathways (Hunter and Segrott 2014, Reed et al 2016). Adopting this wider approach might enable us to see new patterns of emotional work emerging across professional groups both within and beyond the health sector.

Post-mortem as a form of health work has been underexplored in literature on emotional work. Furthermore, while research has started to focus on the increasing personalisation of post-mortem (Schafer 2012), ethnographies in this area continue to be centrally concerned with dissection and pathology (Ashforth and Kreiner 1999, Gassaway 2007, Horsley 2008, 2012; Timmermans 2006). We emphasise the value of extending the focus of sociology of emotional work to include the hidden world of post-mortem, as well as broadening the scope of research on post-mortem to include emotional work. Post-mortem cannot be reduced to a set of clinical processes on the body that take place in the mortuary. Rather it involves a

range of practices- such as emotional and care work- that tend to be hidden from public view. Health trusts across the UK are beginning to open their mortuary doors to members of the public in order to demystify these hidden worlds. We argue, therefore, for the development of a more enlightened approach to post-mortem in social research, one which departs from the existing focus on dissection.

Our data indicates that post-mortem practice is changing as emotional and other forms of care work become increasingly central. Such work is clearly highly valued by both professionals and families in this context. Emotional work also appears to be becoming a more accepted part of organisational culture within hospital settings as some of the data in the last section of this article begin to show. These shifts combined, could perhaps be indicative of a broader *affective* turn in production. This is shown by the ways in which ‘feelings’ and ‘emotions’ are being better accepted and integrated into various occupational practices (from business to the military). Affective labour according to Hardt (2007) engages at once with rational intelligence and with passion or feeling. Moving forward the concept of affective labour could offer sociologists a useful tool through which to explore the increasing value of emotions in different forms of work.

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ⁱ A coroner may choose to order a post-mortem if a death is perceived to be sudden, violent or unexplained.

ⁱⁱ For example the UK BBC television crime drama *Silent Witness* or US based crime series such as *Crime Scene Investigation* (CSI).

ⁱⁱⁱ Histopathology is the study of diseased tissue including examination under the microscope.

^{iv} A hospital sluice room is where used disposables such as incontinence pads and bedpans are processed and medical and surgical instruments are sterilized and disinfected.

^v Most respondents referred to the mortuary using a cosy house name- although they didn't know why they did this. We use an anonymised version to protect site identity *Primrose villa*.

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